

**Certification of IRS Qualification as a Tax Dependent**  
**For Health Plan Purposes**  
**Same-Sex Domestic Partner or Child**  
**Per IRC § 105(b) § 152**

I, \_\_\_\_\_ understand that I must pay income tax on the value of the health plan coverage that I have elected for my same-sex domestic partner and/or my same-sex domestic partner's child, unless my same-sex domestic partner and/or same-sex domestic partner's child meets the four requirements for treatment as a tax dependent for health coverage listed below. I further understand that, even if my same-sex partner and/or my same-sex domestic partner's child meet these requirements, he/she/they may not qualify as my dependents on my federal income tax return.

I certify that *(name of dependent or dependents)* \_\_\_\_\_ meets the following requirements of Section 152 of the Internal Revenue Code (IRC).

My dependent *(name of dependent or dependents)* \_\_\_\_\_:

- is a citizen, national or U.S. resident;
- lives with me and is a member of my household;
- lives with me in a relationship that does not violate local laws; and
- receives over half of his/her support from me.

I request that my employer treat the above-named person as my tax dependent for health coverage purposes. I acknowledge that it is my responsibility to notify my employer in writing as soon as possible if there is any change in the status of the above-named person as my tax dependent for health coverage purposes, including any change that may occur mid-year.

\_\_\_\_\_  
SIGNATURE

\_\_\_\_\_  
DATE SIGNED